

**THIS DECISION HAS BEEN APPEALED. THE  
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:  
SOAH DOCKET NO. 453-03-4225.M2**

July 1, 2003

David Martinez  
TWCC Medical Dispute Resolution  
4000 IH 35 South, MS 48  
Austin, TX 78704

MDR Tracking #: M2-03-1335-01  
IRO #: 5251

\_\_\_ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to \_\_\_ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

\_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Orthopedic Surgery. The \_\_\_ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to \_\_\_ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

#### CLINICAL HISTORY

This patient is a 46-year-old male who sustained a work-related injury on \_\_\_ while working for \_\_\_ as a \_\_\_. This injury culminated in June 2000 with a two-level anterior cervical fusion with decompression at C5/ and C6/7 that was performed by \_\_\_. According to the records, this gave the patient some relief, but the pain returned and he also was complaining of pain in the left hand along with numbness in the left hand after surgery. The patient complained of bilateral paresthesias involving both arms.

He was seeing \_\_\_, a spine surgeon, who ordered an EMG with nerve conduction studies on September 18, 2002. these were done by \_\_\_ a physical medicine specialist. They were reported as being normal. The patient apparently continued to complain of neck symptoms with bilateral numbness in both hands so a cervical myelogram and CT scan

were done by \_\_\_\_ on January 29, 2003. This study demonstrated no evidence of pseudoarthrosis and did not demonstrate any evidence of nerve root compression or herniated disc according to the report. The study was reported to be a normal study except for evidence of the successful fusion at C5/6 and C6/7. The patient continued to complain of neck and shoulder pain according to \_\_\_\_ note dated January 31, 2003. \_\_\_\_ then requested a repeat EMG and nerve conduction study on the patient on April 24, 2003. This has been denied by the insurance carrier and this decision is being appealed.

#### REQUESTED SERVICE

An EMG with NCS Bilateral UE is requested for this patient.

#### DECISION

The reviewer agrees with the prior adverse determination.

#### BASIS FOR THE DECISION

There are no records that report any change in this patient's physical status, neurological status or symptoms since his prior EMG done on September 18, 2002 by \_\_\_\_\_. The records do not contain any reported change of symptoms and they do not report any change in his physical findings or neurological findings so the records simply do not support the need for a repeated study at this time.

\_\_\_\_\_ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. \_\_\_\_\_ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of \_\_\_\_\_, I certify that there is no known conflict between the reviewer, \_\_\_\_\_ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

\_\_\_\_\_ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

#### **YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective *spinal surgery* decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other *prospective (preauthorization) medical necessity* disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of

Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

**I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 1<sup>st</sup> day of July 2003.**